STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085009	A. BUILDING _____ B. WING _____	C 10/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST MANOR HOUSE	1001 MIDDLEFORD ROAD SEAFORD, DE 19973

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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from October 15, 2012 through October 24, 2012. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 51. The stage two survey sample was thirty-two (32).	F 000	**Disclaimer Statement** Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction of prepared and/or executed solely because it is required by the provision of federal and state law. This Plan represents the facility's credible allegation of compliance.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157	F157 1. Resident R39 had a significant weight loss in June 2012. Deficient practice of not reporting weight to physician and family occurred. Resident regained weight after one week. This issue cannot be corrected today. 2. All residents will have a monthly or weekly weight done of need determined and reviewed by Nutritional Case Manager the same day weights obtained.	12/17/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn K Hankinson — TITLE: Executive Director — (X6) DATE: 11/15/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that for one (R39) of 32 sampled residents, the facility failed to immediately consult with the physician and immediately notify R39's family about the resident's severe weight loss. Findings include: Cross refer F325. The facility's "Nutrition Services" policy and procedures entitled, "Weight Gain/Loss" was reviewed. The "Procedure" included: "3. All individuals with significant weight changes will be re-weighed to assure accuracy of the weight prior to reporting this to the staff, physician, or family. 4. The individual, family (or legal guardian), physician and RD/NCC/NSM will be notified by a member of the nursing staff of any resident with an unplanned significant weight changes of 5% in 30 days, 7.5% in 90 days, or 10% in 180 days." The facility's "Nursing Manual" policy and procedures entitled, "Weight or Height Guidelines" was reviewed. The "Procedure" included: "6. Notify the dietician (utilizing the Communication to Culinary Services, form ...), and the resident's physician if any of the following	F 157	3. Nutritional Case Manager will identify any significant weight loss. Nutritional Case Manager will inform charge nurse that a re-weight is needed within 24 hours. If weight loss is still significant, Nutritional Case Manager gives a written dietary consult to charge nurse. Charge nurse notifies physician, Registered Dietician and family. Three day calorie count initiated. Resident is placed on weekly weights and resident is reviewed weekly at interdisciplinary standards of care and Nutritionally At Risk meeting. Resident's overall condition, meal consumption % and weights will be discussed. Physician and Registered Dietician's recommendation will be implemented by nursing. Family will be notified by charge nurse of any new orders. 4. All residents weight will be audited monthly by Director of Nursing for accurate reporting and all findings will be presented at monthly QA x 3months then quarterly QA for one year.	12/17/12

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F 157	Continued From page 2 occur: a. Resident loses or gains more than 5 pounds in a month. b. Resident loses or gains more than five percent (5%) of his/her body weight in 30 days." R39 was readmitted to the facility on 6/2/12 from the hospital following treatment for urinary tract infection with sepsis syndrome and weighed 129 pounds (#). R39's subsequent weekly weights documented the following: - 6/6/12: 129.2# - 6/14/12- 123.4# (5.8# variance) - 6/15/12- 122.0# (reweight, weight loss of 7.2# or 5.5% since admission) Although the facility completed a reweight on 6/15/12 to confirm a severe weight loss, record review lacked evidence that the facility identified the weight loss. In addition, record review and interview lacked evidence that the facility notified the physician and R39's family. An interview with E2 (Director of Nursing) on 10/23/12 at approximately 2:45 PM confirmed that R39's family was not notified of the resident's weight loss. An additional interview with E19 (Nurse Practitioner) on 10/24/12 at 2 PM confirmed that he was not informed of the resident's weight loss.	F 157		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;	F 242		

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F 242	Continued From page 3 interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility systems it was determined that the facility failed to ensure baths/showers were scheduled based on individual resident assessments. Findings include: During stage1survey review 3 (anonymous) out of 21 residents interviewed replied "no" to the question "Do you choose how many times a week you take a bath or shower?" An interview on 10/19/12 at 10:45 AM interview with CNA E13 revealed that there was a bath book with a day and time assigned to each room. Each resident was scheduled twice a week. The schedule was done by room but can be changed by resident request. Review of the bath book noted a list of all resident room numbers with the day of the week and shift that the bath was scheduled. There were no names included on the list. An interview on 10/23/12 at 2 PM with E8 RN, confirmed residents were assigned showers by their room number. If a resident requests a different schedule they try go get another resident to trade so that the schedule would be balanced for the staff. E8 further stated that the facility would still accommodate the resident even if no	F 242	F 242 1. Corrective action cannot be made for the (3) anonymous residents who replied "No" to the question, "Do you choose how many times a week you take a bath or shower"? 2. All residents will be asked when they want their shower and how often. 3. A new shower schedule will be made to accommodate their requests. It will also be added to their plan of care. All new residents will be asked upon admission if they have a preference for a shower day and time. A change in their shower time and day will be evaluated and granted upon request. 4. All residents will be interviewed quarterly to see if their preferences have been honored and reported at quarterly QA meeting x 2.	12/17/12

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F 242	Continued From page 4 one would change their schedule. E8 confirmed that residents were not being asked for their preference of bath days and times rather a room specific schedule was being used. E8 stated that the facility could look into asking residents on admission about their bathing schedule.	F 242	F 247 1. Resident (R49) was not told in February 2012 that she was getting a new roommate. This deficient practice cannot be correct today.	
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to inform one (R49) out of 32 residents sampled, that a roommate would be moving into her room prior to arrival. Findings include: There was no evidence in the social service notes or nurse's notes to indicate that R49 was getting a roommate in February of 2012. The roommate, R9, was being admitted from outside of the health care center on 02/13/12. An interview with E14 (Social Services Director) on 10/19/12 at 9:45AM, indicated that if notification wasn't in the social services notes or nurse's notes in the chart, it may not have been done.	F 247	2. Any resident getting a new roommate will be notified by social service and in lieu of social services, nursing will notify resident or resident's family of change. Social services or nursing will write a note in resident's chart verifying this occurred. Social Services Director will do an audit of all room changes and new admissions for the past 3 months and report finding in December 2012 at the QA/QI meeting. 3. Social Service Director will do quarterly audit of all room changes or new admissions x 2 to ensure notification was given and documented. 4. Social Services will report findings in quarterly QA meeting x 2 (January & April 2013)	12/17/12
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278		

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F 278	Continued From page 5 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined that for one (R39) out of 32 sample residents, the facility failed to ensure that the assessment accurately reflected the resident's status and ensured that each individual who completed a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Findings include:	F 278	F 278 1. Resident (R-39) did not have a correct weight in June 2012. NCM did not sign MDS. This deficient practice cannot be corrected today. 2. RD and NCM will take correct weight from the weekly weight monitoring record to place on MDS during the reference period. Either Asst Director of Nursing or Nutritional Case Manager who does MDS will ensure their signature is on MDS. 3. MDS Coordinator will audit all MDS' for past one month to ensure compliance and MDS coordinator will not submit MDS to CMS without verifying all signatures are obtained first. 4. MDS Coordinator will report all findings of the audit at the monthly QA/QI in December 2012. MDS Coordinator will do an audit for signatures for first quarter of 2013 and report findings in April 2013 QA meeting.	12/17/12

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F 278	Continued From page 6 Cross refer F325. Review of R39's weight record revealed the following: - 6/2/12: Admission weight of 129 pounds (#). - 6/6/12: 129.2# - 6/14/12: 123.4# (5.8# variance) - 6/15/12: 122.0# (reweight, weight loss of 7.2# or 5.5% since admission) Review of the Prospective Payment System 14 day Minimum Data Set (MDS) assessment dated 6/16/12 incorrectly documented in "Section K" that R39's most recent weight was 129# and that the resident did not have a weight loss of 5% or more even though the severe weight loss was confirmed on 6/15/12 as documented above. "Section Z" of this assessment failed to include the health professional signature and title who completed "Section K" and the date that the section was completed. An interview with E2 (Director of Nursing) on 10/26/12 at approximately 11:45 PM confirmed the above findings.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		

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F 279	Continued From page 7 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to develop a care plan for identified needs for 2 (R58 and R54) out of 32 sampled residents. Findings include: 1. Review of R58's admission Minimum Data Set assessment dated 7/15/12 documented R58 was planning on returning to the community. Review of an Occupational Therapy note dated 10/10/12 recommended R58 was to be discharged to Assisted Living. On 10/23/12 at 12:45 PM an interview with E2 (DON) revealed R58 was discharged from the skilled unit on 10/19/12 but remained in the facility. R58 agreed to go to the assisted living unit instead of independent living. The facility was waiting for R58's apartment to be ready. R58's care plan failed to include a care plan for community discharge. Review of R58's care plan with E14 (social worker) on 10/24/12 at 10:59 AM confirmed the	F 279	F 279 1. Resident (R58) was identified as not having a discharged care plan. A discharge care plan has been developed by interdisciplinary care plan team. 2. All residents with the potential for discharge have been identified and discharge care plans are being developed for those residents. 3. Care plans will be initiated on admission, reviewed and updated weekly during Medicare and utilization review meetings by ADON. Care plans will be ongoing until discharged. 4. MDS Coordinator will do monthly audits on completion of all discharge care plans and submit findings at monthly QA meeting x 3 then quarterly x 1 year.	12/17/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 279	Continued From page 8 facility failed to develop a care plan for R58's return to the community. On 10/24/12 at 11:26 AM review of R58's care plan with E12 registered nurse assessment coordinator (RNAC) revealed it was not the facility's practice to develop discharge care plan for residents for a planned community discharge. 2. R54's October 2012 physician order sheet revealed an order for Melatonin 3 mg one by mouth at bedtime for insomnia. Review of R54's care plan dated 8/16/12 documented "Resident has episodes of insomnia" with goals that included "Resident will sleep 6-8 hours a night by next review". However, the facility failed to include any interventions/approaches for this problem. On 10/18/12 at 12:35 PM review of R54's care plan with E8 (LPN) and at 1:05 PM with E12 (RNAC) confirmed the facility failed to complete R54's care plan to include interventions/approaches addressing her insomnia.	F 279	1. Resident (R54) was identified as not having a completed care plan for insomnia. A care plan has been developed by nursing. 2. All nurses have been assigned specific residents to review and update all care plans. 3. Weekly audits of all care plans have been divided between Asst Director of Nursing, MDS Coordinator and supervisors to ensure accuracy of all care plans. Audits will be submitted to Director of Nursing weekly for review and follow-up. 4. Director of Nursing will report findings at monthly QA meeting and quarterly QA meeting for one year.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	F 280		12/17/12

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F 280	Continued From page 9 interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview it was determined that the facility failed to review and revise care plan for one (R26) out of 32 sampled residents. Findings include: 1. Cross refer F309 example 1 Review of R26's physician orders as recommended by the speech therapist revealed the following: - 5/10/12 "Regular diet" - 6/26/12 "Continue Aspiration Precautions and meals in dining room for verbal cueing as needed. Check mouth for pocketing after all by mouth intake and assist with clearance as needed." - 8/11/12 "Thin liquids". All these orders were carried over to the October 2012 physician order sheet. Review of R26's care plan revealed she had the following: a. Nutrition/Hydration Risk Care Plan dated 4/24/12. This care plan had different	F 280	F280 1. Resident (R26) was identified as not having a completed care plan. A care plan has been developed by nursing. 2. All nurses have been assigned specific residents to review and update all care plans. 3. Weekly audits of all care plans have been divided between Asst. Director of Nursing, MDS Coordinator and supervisors to ensure accuracy of all care plans. Audits will be submitted to DON weekly for review and follow-up. 4. Director of Nursing will report findings at monthly QA meeting and quarterly QA meeting for one year.	12/17/12

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F 280	Continued From page 10 approaches/interventions listed. Staff were required to place a check mark by the interventions/approaches that were required for the resident. Listed for approaches for R26 failed to include "Provide cueing to eat and drink liquids during meal time and between meals. Monitor and report signs/symptoms of aspiration." b. Potential for aspiration related to dysphagia secondary to pocketing food with an approach of resident will tolerate the following diet "mechanical soft with thin liquids". Review of R26's physician orders revealed an order for a regular diet with thin liquids not mechanical soft. Review of R26's care plan on 10/23/12 at 10:22 AM with E15 (LPN) and E16 (Rehab manager) revealed R26's care plan was not reviewed and revised to include R26's regular diet with thin liquids, interventions for cueing the resident while eating and drinking, check mouth for pocketing after all by mouth intake or that R26 was to eat her meals in the dining room.	F 280		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, observation, record review	F 309		

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F 309	Continued From page 11 and review of other documentation as indicated it was determined that the facility failed to ensure that five (5) (R7, R26, R18, R62 and R20) out of 32 sampled residents received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The facility failed to ensure R26 was being assessed and monitored for her dysphagia/aspiration precautions. The facility failed to consistently evaluate pain before and/or after medication administration for R7, R18 and R62. The facility failed to assess and provide ordered treatments for constipation for R7 and R20. Findings include: 1. R26 was admitted to the facility with diagnoses that included congestive heart failure, chronic obstructive pulmonary disease, dementia, depression, flash pulmonary edema, and hypertension. Review of R26's speech therapy evaluation dated 6/29/12 revealed "R26 was recommended to continue with regular solids and thin liquids: meds (medications) should be crushed and offered in pudding to offer a sweeter taste to counteract the bitterness she complains of with crushed meds; continue meals in dining room for verbal cueing as needed; check for pocketing after all p.o. (by mouth) intake and assist with clearance as needed; continue with aspiration precautions." R26 had current October 2012 physician orders that were initiated on the following dates: 1/11/12 "Precautions:Aspiration", 6/26/12 "Continue	F 309	F 309 1. Resident (R26) plan of care was reassessed. Physician orders, care plan and CNA data sheet reviewed. Staff educated. 2. An audit of all residents on aspiration precautions was implemented to ensure compliance. A blue star program will be initiated to alert staff of what residents are on aspiration precautions. Blue star will be placed on the meal/name tag of identified residents. All staff will be educated. 3. All residents on aspiration precaution will be discussed weekly at standard of care meeting to ensure compliance with their plan of care. 4. Finding will be presented by Director of Nursing at monthly QA meeting and quarterly meeting for one year.	12/17/12

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F 309	Continued From page 12 Aspiration Precautions and meals in dining room for verbal cueing as needed. Check mouth for pocketing after all by mouth intake and assist with clearance as needed." Review of R26's care plans revealed Potential for aspiration initiated on 1/18/12 related to dysphagia secondary to pocketing food with interventions that included -head of bed elevate 90 degrees upright and midline for all oral intake and 30 minutes following -provide diet as ordered This care plan was reviewed on 7/27/12 stating no episodes noted with pocketing food and or meds. Continue with current plan. Review of R26's Nutrition/hydration risk care plan problem dated 4/24/12 stated "Resident is at nutrition/hydration risk related to needs assistance/cueing diagnoses dementia, chronic obstructive pulmonary disease and congestive heart failure" with interventions that included: -provide diet as prescribed ... -provide necessary assistance at meal time and between meals Review of R26's Treatment Administration Record for October 2012 revealed nursing was documenting on every shift that R26 was on "aspiration precautions". Review of the CNA Data Book revealed a "Patient Care Plan" for R26 that documented "Eating habits feeds self". On 10/23/12 R26 was observed eating breakfast at 9:30 AM in the dining room. R26 was slow in	F 309	1. Residents (R7, R18, R62) were identified as not having pain consistently evaluated. Staff was re-educated on the proper way to complete pain flow sheet. 2. An audit of all residents receiving pain medication was implemented to ensure compliance. 3. Meeting with pharmacy representative on 11/13/12 resulted in having pain flow sheet information placed into the electronic medication pass. The paper flow sheet will be eliminated. Facility will use only one rating scale for verbal residents and one pain rating scale for non-verbal residents. Staff education will begin upon implementation of program. Target date 11/19/12 4. Monthly audits of pain management will be completed by MDS Coordinator. Findings will be presented at monthly QA and quarterly QA for 1 year.	12/17/12

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F 309	Continued From page 13 eating and easily distracted. Staff members were observed preparing the dining room for chapel services. R26 was observed eating an orange then said "I forgot what I was doing". Surveyor told her she was eating an orange. R26 began peeling her orange slice and continued to eat. R26 was observed putting a piece of a waffle in her mouth. R26 chewed the piece of waffle for a few seconds, stopped chewing watched the staff moving the furniture, waited then swallowed her waffle before chewing it completely. E17 (CNA) asked R26 if her coffee was cold and if she was finished. However, E17 did not assist or cue R26 with eating. From 9:30 AM until 9:50 AM no one was observed assisting or cueing R26 with eating or drinking or checking to see if she was pocketing her food. On 10/23/12 at 12:10 PM R26 was observed eating soup. At 12:35 PM E17 (CNA) was asked if R26 was on aspiration precautions. E17 stated "no she feeds herself". On 10/23/12 at 12:55 PM E18 (CNA) was asked if R26 was on aspiration precautions. Before answering E18 went to the CNA Data Book and pulled up R26's Patient Care Plan. After reviewing R26's Patient Care Plan E18 stated "No she feeds herself". E18 stated that each resident has a Patient Care Plan that tells the CNAs the care to provide for the resident. Review of R26's record with E15 (LPN) and E16 (Rehab Manger) on 10/23/12 at 12:58 PM revealed R26 was on Aspiration Precautions, meals were to be served in the dining room and the staff should have been providing verbal cueing for R26 as needed. The staff should also	F 309	1. All bowel movement records were reviewed to ensure no resident was constipated. 2. All nurses were re-educated on how to check, prior to their medication pass, what residents have not had BM x 3 days. 3. Weekly audits will be completed by 7-3 supervisor to ensure this deficient practice does not recur. Findings will be submitted to Asst. Director of Nursing for review. 4. Asst. Director of Nursing will present findings at monthly QA meeting x 3 then quarterly x 1 year.	12/17/12

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F 309	Continued From page 14 check her mouth for pocketing after all by mouth intake and assist with clearance as needed. However, this information was not relayed to the CNA staff by way of R26's Patient Care Plan used by the CNAs. On 10/24/12 at 3:04 PM review of the concerns were reviewed with E1 (Administrator) E2 (DON) E3 (ADON) and E4 (Regional DON). 2. The pain management standards were approved by the Joint Commission in July 1999 and the same guidelines were approved by the American Geriatrics Society in 2002 and again in 2009 which included: - appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. The facility's policy for pain management indicated the Pain Management Tool would be used to assess pain and document findings. R18 had diagnoses that included hypertension, Alzheimer ' s disease and a pelvic mass. A review of R18 ' s medical record revealed a visit to an oral surgeon on 10/19/12. The oral surgeon documented an impression of probable Cancer in the area of the right mandible and probable metastatic disease. The oral surgeon suggested palliative care and an increase in pain medication	F 309		

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F 309	Continued From page 15 along with an antibiotic. A MDS (Minimum Data Set assessment) dated 7/19/12 documented that R18 ' s cognitive skills were moderately impaired. Section J of the MDS documented that during the last five days the resident had been on a scheduled pain medication regimen, did not receive any PRN (as needed) medication, did not receive any non-medication interventions for pain and that R18 should have a pain assessment interview conducted. This interview documented that the resident denied the presence of pain. The prognosis documented in the MDS stated that R18 had a condition that may result in a life expectancy of less than 6 months. A care plan for " Hospice program " related to a pelvic mass dated 4/19/12 and last updated 9/24/12 revealed a goal that R18 ' s pain would be controlled as evidenced by: " resident verbalized pain tolerable. " Interventions included: Follow hospice plan of care, evaluate for pain frequently and assess for effectiveness of pain medication (E2 confirmed on 10/25/12 at approximately 1:45 PM, there was no care plan developed by hospice related to pain management). A Quarterly " Pain Status Report " completed by E12 on 7/3/12 documented " Resident was non-verbal upon asking of any pain. " E12 documented use of the Wong-Baker Faces pain rating scale and rated R18 ' s pain as " 0. " An interview on 10/24/12 at approximately 1:25 PM, E12 stated she compared R18 ' s face to the faces on the Wong-Baker pain scale to determine	F 309		

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R18 ' s pain level. E12 also stated there were no directions on how to use the faces pain rating scale included with the " Pain Status Report. "

The Wong-Baker Faces Pain Rating Scale is the tool the facility was utilizing according to E2 (Director of Nursing) during an interview on 1019/12 at approximately 1:00 PM.

According to the Wong - Baker FACES Foundation, this pain rating scale is used in the elderly population for persons with moderate to severe dementia who have lost much of their ability to use language to describe pain. This scale uses faces from happy to tearful to demonstrate how a person might be feeling. It should be used only after the person in pain has demonstrated an inability to make use of the " 0 " to " 10 " pain scale. To utilize this approach of pain assessment, show the card with the faces to the resident. Explain to the resident the severity of pain that each face represents and then have the resident point to the face that best describes their current pain level. The face will correspond with a number ranging from 0-10 which is the scale the nurse will utilize to assess and reassess the resident ' s level of pain.

Interview with E2 and E4 on 10/19/12 at approximately 1:00 PM revealed that the nursing staff was utilizing the Wong-Baker Faces pain rating scale when assessing pain for a resident who cannot express a pain rating. E4 stated that the nursing staff was comparing the resident ' s face with the faces on the Wong-Baker scale to make a decision about how much pain the resident was experiencing. The Wong-Baker Faces Pain Rating Scale is a tool that is intended

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to be used with residents who are able to point to a face that the resident feels best describes their own pain. This pain tool is not intended to be used by nurses who compare the residents face to the faces on the scale and then determine the amount of pain the nurse believes the resident is experiencing.

The Face Legs Activity Cry Consolability (FLACC) Scale is a behavioral scale used to score pain and was developed to be used in persons who are unable to communicate. This FLACC scale was developed to provide a structure for pain assessment and an objective means of quantifying pain behaviors. This scale includes five categories of pain behaviors, including facial expression, leg movement, activity, cry and consolability. Each section is scored on a 0-2 scale and then the scores are added together which allows for a comprehensive assessment of the resident ' s pain.

An interview on 10/18/12 at approximately 11:00 AM with E12 revealed Delaware Hospice was utilizing the FLACC scale to assess R18 ' s pain level.

Medical record review for October 2012 revealed a pain assessment flow sheet that was completed by staff nurses each shift. During the month of October 2012, the staff nurses indicated R18 experienced pain by documenting " yes " in the computerized pain assessment flow sheet. During the 66 shifts, there was indication of pain for 8 shifts.

According to the standard of practice and confirmed by E2 (DON) during an interview on

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F 309	Continued From page 18 10/19/12 at approximately 1:00 PM, when the nurse documented the presence of pain, a pain assessment would be completed and documented on the PRN (as needed) pain flow sheet (paper form). Record review revealed on 10/11/12 the pain flow sheet documented an incomplete pain assessment. On 10/13/12 a pain assessment was documented but no reassessment was completed. There was no evidence that the remaining 6 episodes of pain were assessed and documented on the PRN pain assessment form. Although the facility initially assessed R18 ' s pain as " yes " in the electronic MAR, the facility failed to comprehensively assess and reassess the resident ' s pain using an appropriate pain assessment tool for nonverbal residents, as is the current standard of practice. 3. R7's minimum data set assessment (MDS) dated 8/2/12 indicated the resident was moderately impaired for decision making and that the resident was on a scheduled pain medication regime with no PRN (as needed) pain medication usage. MDS resident interview documented the resident had no pain at the time of the assessment. R7 had a care plan initiated on 10/5/10 and last reviewed 9/27/12 for pain management related to a history of compression fractures. Approaches included to use pain scale 1 - 10 and to assess pain level when resident requests pain medication.	F 309		

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F 309	Continued From page 19 R7 had current October 2012 physician's orders for tramadol 50 mg three times a day for pain on a routine basis initiated 5/21/12. The resident also had orders for oxycodone 5 mg 1/2 tablet for mild to moderate pain or 1 tablet for moderate to severe pain every eight hours as needed (PRN) initiated on 7/16/12 and acetaminophen (APAP) 650 mg every 4 hours PRN for mild pain initiated on 2/6/09. Review of the August 2012 medication administration record (MAR) documented that R7 was administered 3 doses of APAP and 2 doses of oxycodone. Review of the Pain Flow Sheet documented 2 of the doses of APAP and 1 dose of oxycodone with pain assessment before and after administration using the pain scale. There was no evidence that the resident was assessed for the other two doses of PRN pain medication. Review of the September 2012 MAR documented the resident was administered 14 doses of PRN oxycodone and one dose of APAP. The facility used the Pain Flow Sheet for 5 of the doses however the pain scale was not used for any of the 5 doses. Review of the October 2012 MAR documented R7 received 10 PRN doses of oxycodone and 2 doses of APAP. Review of the Pain Flow Sheet documented only 3 of the doses and included the use of the pain scale for these three doses. An interview with Administrator E1 and DON E2 on 10/23/12 at 3 PM confirmed that the facility was not consistently using a pain scale to rate pain before and after administration of R7's PRN pain medication.	F 309		

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F 309	Continued From page 20 Additionally R7also failed to receive the care and services pertaining to treatment and evaluation of constipation. R7 had a diagnosis of constipation and was on oxycodone for pain which can cause constipation. The resident had current October 2012 physician's orders for: -Milk of Magnesia (MOM) 30 cc by mouth PRN for constipation. Give if no bowel movement (BM) on third day -Dulcolax rectal suppository PRN constipation if MOM ineffective by 6 AM -Fleet enema rectal 1 time a day if dulcolax suppository ineffective by noon The resident had a care plan initiated on 10/5/10 and last review on 9/27/12 for high risk constipation due to decreased mobility with a goal and approaches that included; -Will establish a regular bowel pattern by having a BM at least every three days. -Follow bowel protocol, accurate BM documentation in care tracker (electronic documentation), initiate BM alerts in care tracker, monitor food and fluid intake and consult with dietician as needed, and monitor medication use for cause of constipation. Review of the electronic medical record in the facility's care tracker system revealed the following periods with no BMs greater then nine shifts: 8/18 - 8/23/12 15 shifts	F 309		

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F 309	Continued From page 21 9/2 - 9/6/12 12 shifts 9/6 - 9/11/12 12 shifts (two small BMs recorded) 9/12 - 9/17/12 12 shifts 9/21 - 9/27/12 17 shifts 9/30 - 10/4/12 11 shifts 10/9 - 10/16/12 20 shifts (10/15 dulcolax suppository administered at 10:33 PM) Review of the MAR and nurses' notes lacked evidence of an assessment or intervention after nine shifts with no BMs until 10/15/12. A nurse's note dated 10/15/12 and timed 10:50 PM documented "resident complaint of constipation at 10:34 PM could not pass her stool and she was in pain from pushing and bearing down. Request pain medication as it hurt really bad. She was toileted, rectal area massaged and repositioned. Medication with oxycodone and suppository given". An interview on 10/23/12 at 3 PM with E2 (DON) confirmed there was no evidence that R7's constipation was monitored for the above time periods. E2 revealed that there was a change in electronic documentation systems and it did not appear that staff were consistently running the BM monitoring reports. 4. R62 was admitted to the facility with diagnoses that included anxiety, new compression fracture L4 and L3, osteoporosis, vertebral compression fracture L5 kyphoplasty, restless leg, and rheumatoid arthritis. Review of R62's initial pain assessment sheet	F 309		

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revealed that the facility put R62's name on the pain assessment sheet and documented she had pain. The rest of the pain assessment form that included R62's pain history, descriptors of pain, location of pain, and pain management sections was not completed. On 10/24/12 at 12:30 PM this form was reviewed with E9 (RN) and E2 (DON) who confirmed that the facility failed to complete an initial pain assessment for R62.

R62 had a physician order dated 9/26/12 for Percocet Oral tablet 5-325 mg one tablet by mouth every 6 hours as needed. This order was discontinued on 10/12/12 and a new order was obtained for Percocet Oral tablet 5-325 mg one tablet by mouth every 4 hours as needed for break through pain.

R62 had a care plan for Alteration in comfort secondary to compression fractures with interventions that included
-assess type, frequency, duration and location of pain
-establish acceptable pain level
-medications as ordered; monitor for effectiveness

Review of R62's Medication Administration Record for October 2012 revealed she received the Percocet PRN on 49 different occasions between 10/1/12 through 10/24/12. Of these 49 occasions 11 times a pre and post medication assessment was completed using the pain rating numerical system. For 18 occasions a pre assessment was completed using the pain numerical system however as a post assessment a "+ or effective" was written instead of using the numerical system. For the last 20 occasions

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F 309	Continued From page 23 there was no evidence that a pre and post pain assessment was completed using the numerical pain scale in order to measure the effectiveness of the medication. Review of R62's pain flow sheet on 10/24/12 at 12:45 PM with E9 (RN) confirmed that the facility failed to consistently assess and reassess R62's pain before and after the administration of pain medication using their numerical pain scale in order to measure the effectiveness of the medication. 5. R20 had a diagnosis of constipation and the resident had September 2012 and October 2012 physician's orders for: - MOM 30 cc by mouth PRN for constipation. Give if no bowel movement (BM) on third day - Dulcolax rectal suppository PRN constipation if MOM ineffective by 6 AM - Fleet enema rectal 1 time a day if dulcolax suppository ineffective by noon Review of the electronic medical record in the facility's care tracker system revealed that from the evening shift on 9/29/12 through the night shift on 10/3/12 for total of 11 shifts, R20 had no documented BM activity. Review of the September 2012 and the October 2012 MAR and nurses' notes lacked evidence of an assessment or intervention after nine shifts with no BMs. An interview with E2 on 10/23/12 at	F 309		

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F 309	Continued From page 24 approximately 2:45 PM confirmed the above findings.	F 309		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interviews, and review of facility's policy and procedures, it was determined that the facility failed to maintain acceptable parameters of nutritional status such as body weight for one (R39) of 32 sampled residents. The facility failed to monitor R39's oral intake, failed to reassess the interventions, and failed to identify a severe weight loss on 6/15/12. Findings include: The facility's "Nutrition Services" policy and procedures entitled, "Weight Gain/Loss" was reviewed. The "Procedure" included: "1. A copy of weight records will be forwarded by a member of the nursing staff to the appropriate culinary and nutrition professional each month (registered dietician/RD), nutrition care coordinator (NCC), or nutrition service manager	F 325	F 325 1. Resident R39 had a significant weight loss in June 2012. Deficient practice of not reporting weight to physician and family occurred. Resident regained weight after one week. This issue cannot be corrected today. 2. All residents will have a monthly or weekly weight done if need determined and reviewed by Nutritional Case Manager same day weights obtained.	12/17/12

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	085009	A. BUILDING _____ B. WING _____	C 10/24/2012

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F 325	Continued From page 25 (NSM). The RD, NCC, or NSM will review monthly weights and calculate significant changes over 30 days, 90 days, and 180 days. Weights will also be reviewed for trending of loss or gain. A copy of all significant weight losses and gains and trending weight losses and gains will be given to the care team for appropriate review and documentation. 2. The care team will review and document on all significant weight changes/trends, with appropriate referrals to the RD, NCC, or NSM. The RD, NCC, or NSM will review all significant weight changes/trends and referrals and take action as necessary (including follow-up documentation). 3. All individuals with significant weight changes will be re-weighed to assure accuracy of the weight prior to reporting this to the staff, physician, or family. 4. The individual, family (or legal guardian), physician and RD/NCC/NSM will be notified by a member of the nursing staff of any resident with an unplanned significant weight changes of 5% in 30 days, 7.5% in 90 days, or 10% in 180 days." The facility's "Nursing Manual" policy and procedures entitled, "Weight or Height Guidelines" was reviewed. The "Procedure" included: "6. Notify the dietician (utilizing the Communication to Culinary Services, form ...), and the resident's physician if any of the following occur: a. Resident loses or gains more than 5 pounds in a month. b. Resident loses or gains more than five percent (5%) of his/her body weight in 30 days."	F 325	3. Nutritional Case Manager will identify any significant weight loss. Nutritional Case Manager will inform charge nurse that a re-weight is needed within 24 hours. If weight loss is still significant, Nutritional Case Manager gives a written dietary consult to charge nurse. Charge nurse notifies physician, Registered Dietician and family. Three day calorie count initiated. Resident is placed on weekly weights and resident is reviewed weekly at interdisciplinary standards of care and Nutritionally At Risk meeting. Resident's overall condition, meal consumption % and weights will be discussed. Physician and Registered Dietician s recommendation will be implemented by nursing. Charge Nurse will notify family of any new orders. 4. All residents weight will be audited monthly by Director of Nursing for accurate reporting and all findings will be presented at monthly QA x 3months then quarterly QA for one year.	12/17/12

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F 325	Continued From page 26 R39 was readmitted to the facility on 6/2/12 from the hospital following treatment for urinary tract infection with sepsis syndrome with diagnoses including hypertension, hyperlipidemia, diabetes mellitus type II (DM II), peripheral vascular disease, coronary artery disease, osteoarthritis, peripheral neuropathy, degenerative joint disease, status post bilateral hip replacement, status post cholecystectomy, and dementia. The 5 day Minimum Data Set (MDS) assessment dated 6/9/12 documented that R39 was severely impaired for daily decision making, required extensive assistance of one staff person for eating, height and weight were 64 inches and 129 pounds (#) respectively. Review of R39's readmission "Nutrition Risk Assessment" dated 6/2/12 completed by E6 (Registered Dietician) revealed that resident's weight on 6/2/12 was 129#, had no edema (swelling), R39 historically had good to fair appetite, consumed 51%-100% of her meals, and R39's usual body weight for the past 6 months was 128-130#. R39 was assessed at risk for unintended weight loss due to DM II. The plan was to care plan for a weight goal was to maintain weights without significant change. Interventions included to provide diet as prescribed, provide diabetic afternoon snack, honor food preferences, provide necessary assistance at meal time and between meals, allow eating at own pace, monitor weekly weight, monitor oral intake of fluids. Review of 39's "Nutrition/Hydration Risk Care Plan" dated 3/27/12 included goals that resident will maintain weight of 130 (pounds) plus or	F 325		

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F 325	Continued From page 27	F 325		

minus 5 pounds by 90 days and that the resident will exhibit no signs or symptoms of dehydration. Interventions included:
- Monitor through Nutrition Alert Committee.
- Monitor oral intake of food and fluids.
- Monitor weights monthly.

Although the resident was on weekly weights due to readmission to the facility on 6/2/12, the above care plan lacked evidence of the change in the frequency of the weight to be obtained.

Review of R39's meal intake records from 6/4/12 through 6/12/12 (nine days) documented that her consumption was poor. For 10 out of 27 meals, R39 consumed 0%-25% of her meal and that on an average, R39 consumed 48% of her meals during this period of time.

R39's weight on 6/6/12 was documented as 129.2#. The "Nutrition Alert Meeting Minutes" (Nutrition Alert Committee) dated 6/13/12 documented "Pending wt. (weight)." This document lacked evidence that E6 or a staff of the Nutrition department was present.

An interview with E5 (NSM) on 10/24/12 at approximately 1 PM revealed that the monitoring of the meal consumption was completed by the nursing staff and in addition, on a weekly basis, copy of the report was forwarded to E6 for monitoring of oral intake and in preparation for the Nutrition Alert Meeting.

Although R39's meal intake was poor, record review lacked evidence that the facility monitored the oral intake, re-evaluated the current interventions to determine the effectiveness in

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F 325	Continued From page 28 attaining identified nutritional and weight goals. R39's subsequent weekly weight documented the following: -6/14/12- 123.4# (5.8# variance) -6/15/12- 122.0# (reweight, weight loss of 7.2# or 5.5% since admission) Although the facility completed a reweight on 6/15/12 to confirm a weight loss, record review lacked evidence that the facility identified the severe weight loss . Review of the subsequent MDS assessement dated 6/16/12 incorrectly documented R39's most recent weight of 129# and that the resident did not have a weight loss of 5% or more even though the severe weight loss was confirmed on 6/15/12 as documented above. Additional review of R39's meal intake records from 6/13/12 through 6/19/12 (seven days) revealed intake remained poor. For 10 out of 21 meals, R39 consumed 0%-25% of her meal and that on an average, R39 consumed 51% of her meals during this period of time. The subsequent "Nutrition Alert Meeting Minutes" dated 6/20/12 was reviewed which documented "122# need re-weight, meal % 25-75%." This documentation included signatures of E5 and E6. An interview with E6 on 10/23/12 at approximately 2:45 PM revealed that a re-weight was needed following the weight obtained on 6/15/12 even though this was a re-weight of the weight obtained on 6/14/12. No further information was provided.	F 325		

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F 325	Continued From page 29 Despite the fact that R39 had a severe weight loss confirmed on 6/15/12, the facility failed to identify the weight loss. In addition, record review and interview lacked evidence that the facility reassessed the interventions, and failed to notify the physician and R39's family. An interview with E2 (Director of Nursing) on 10/23/12 at approximately 2:45 PM confirmed that the facility had no evidence once the severe weight loss was confirmed on 6/15/12, the facility reassessed the current interventions, and notified R39's family and the physician. The subsequent weekly weight on 6/21/12 documented that R39's weight of 125#. Despite the lack of facility interventions the resident gained weight. Meal observations on 10/22/12 at approximately 12:15 PM and 10/23/12 at approximately 12:30 PM revealed R39 was consuming her lunch meals with staff supervision.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329		

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F 329	Continued From page 30 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, review of other facility documentation and interview it was determined that the facility failed to ensure adequate monitoring for the use of psychoactive medication was completed for 2 (R62 and R20) out of 32 sampled residents. Findings include: The facility's policy and procedures for "Abnormal Involuntary Movement Scale (AIMS Test)" revealed: Procedure: 1. the licensed professional nurse should administer the AIMS test... prior to administration of an anti-psychotic medication and then every three (3) months while the resident is receiving the anti-psychotic medication therapy." 1. R62 was admitted to the facility on 9/25/12 with diagnoses that included anxiety restless leg syndrome and dementia.	F 329	F 329 1. Resident (R62 & R20) was identified as being on antipsychotic medication without having an AIMS test completed. AIMS tests were completed upon notification of findings. 2. All other residents on antipsychotic medications were reviewed. AIMS test were completed. 3. Re-education of nursing staff will be completed. An audit will be completed monthly x 3 by 11-7 nursing supervisor and findings submitted to Asst. Director of Nursing. 4. Findings will be reported in quarterly QA meeting by Asst. Director of Nursing. (January & April 2013)	12/17/12

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F 329	Continued From page 31 Review of R62's physician orders dated 9/25/12 revealed an order for Seroquel (anti-psychotic medication) 25 mg (milligrams) one po (by mouth) at bedtime for insomnia. Review of R62's record lacked evidence that the AIMS test was completed. Review of R62's record with E9 (RN) on 10/18/12 at 2:55 PM confirmed an AIMS test was not completed for R62 for the use of Seroquel. 2. R20 admitted to the facility on 9/25/12 with diagnoses which included dementia with psychosis. R20 was ordered Zyprexa (anti-psychotic medication) 2.5 mg. (milligram) by mouth at 8 PM daily. Record review lacked evidence that the AIMS test was completed. An interview with E2 (Director of Nursing) on 10/13/12 at approximately 1 PM confirmed the findings.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31	F 334		

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F 334	Continued From page 32 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of	F 334	F 334 1. Resident (R20) was admitted to health center from assisted living without immunization record. Upon identification of this by surveyor, records were obtained and record revealed that resident did have pneumococcal vaccine. 2. All residents' records have been reviewed and all residents requesting immunization have been given flu/pneumococcal vaccine. 3. Staff will be re-educated on admission checklist for health center. Confirmation of immunization record for a transferred resident will be ensured. 11-7 charge nurse will audit all new admissions monthly x3 and report finding to Asst. Director of Nursing. 4. Asst. Director of Nursing will report findings in quarterly QA meeting. (January and April 2013)	12/17/12

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F 334	Continued From page 33 pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and review of facility's pneumococcal immunization policy it was determined that the facility failed to ensure that for one (R20) out of five sampled residents, that facility failed to determine whether the resident had his immunization. Findings include: R20 was admitted to the facility on 8/6/12. Record review lacked evidence whether R20 was offered a pneumococcal immunization and/or whether R20 had the immunization. Review of the facility's policy titled "Influenza and Pneumococcal Education & Consent Skilled Care Center Assisted Living Residence" documented in that the consent will be utilized to determine whether the resident received pneumococcal immunization prior to admission and the date. During the survey on 10/24/12 at approximately 2	F 334		

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F 334	Continued From page 34 PM, the surveyor was informed by E2 (Director of Nursing) that the facility obtained evidence that R20 received his immunization in 2009.	F 334	F 428 1. Resident (R20) did not have proper diagnosis for anti psychotic medication. Medical Director was notified and diagnosis obtained. 2. All pharmacy consultant sheets will be reviewed by ADON on a monthly basis for accuracy and completion. 3. Results of findings will be reported in monthly QA meeting. 4. Findings will be reported at quarterly QA by Asst. Director of Nursing x 1 year.	12/17/12
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to act upon the irregularity identified by the licensed pharmacist during a monthly drug regimen review for one (R20) out of 32 sampled residents. Findings include: R20 admitted to the facility on 8/6/12 with diagnoses which included dementia with psychosis. R20 was ordered and administered Zyprexa (anti-psychotic medication) 2.5 mg. (milligram) by mouth at 8 PM daily beginning 8/6/12. Review of the "Medication Regimen Review Sheet" dated 8/30/12 documented that the licensed pharmacist identified an irregularity in which there was no approved psychiatric	F 428		

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F 428	Continued From page 35 diagnosis in the clinical record for the use of Zyprexa. The sheet documented a response from E19 (Nurse Practitioner) of "Pt. (patient) is clinically stable", thus, did not address the irregularity identified. An interview with E2 (Director of Nursing) on 10/17/12 at approximately 1 PM confirmed the findings. Subsequent record review revealed that a new diagnosis of bipolar disorder with delusion was added by the E20 (attending physician) on 10/18/12.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441	F 441 1. Infection control surveillance was not completed for month of September or October 2012. All surveillance has been completed. 2. Infection control is discussed weekly at standards of care meeting. All residents on antibiotics are reviewed and tracked and trended. Monthly surveillance of all infections will be completed by assigned RN. Asst. Director of Nursing will monitor all infection control issues daily. 3. Audit of infection control surveillance will be done monthly by Asst. Director of Nursing. 4. Findings will be reported to quarterly QA by Asst. Director of Nursing x 1 year.	12/17/12

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F 441	Continued From page 36 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on review of clinical record, facility documentation, and staff interviews, it was determined that the facility failed to document and trend infections within the facility from September 2012 through October 2012. Findings include: Review of the facility infection control program documentation revealed that for the months of September 2012 through October 2012, the type of organisms infecting residents were not consistently tracked. This lack of information prevented the facility from trending the organisms to determine if there was a pattern of infection that the facility needed to address.	F 441		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Methodist Manor House Nursing Home

DATE SURVEY COMPLETED: October 24, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual and complaint survey was conducted at this facility from October 15, 2012 through October 24, 2012. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 51. The stage two survey sample was thirty-two (32).	**Disclaimer Statement** Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction of prepared and/or executed solely because it is required by the provision of federal and state law. This Plan represents the facility's credible allegation of compliance.
3201	**Regulations for Skilled and Intermediate Care Facilities**	
3201.1	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report dated 10/24/12, F157, F242, F247, F279, F280, F309, F325, F329, F334, F428, F441.	1. The staff posting was immediately placed on each wing of the health center after being notified that one unit was missing. 2. The charge nurse for each shift will ensure staff posting are on each unit and sign each posting. 3. The staff coordinator will check both units daily upon her arrival and will do a monthly audit x 3 months to ensure charge nurse for all shifts has been signed both copies.

Provider's Signature Eileen K Hanhauser Title Executive Director Date 11/15/2012

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

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STATE SURVEY REPORT

NAME OF FACILITY: Methodist Manor House Nursing Home **DATE SURVEY COMPLETED:** October 24, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
16 Del. C., Chapter 11, § 1162 VII, (a)	**Every residential health facility must at all times provide a staffing level adequate to meet the care needs of each resident, including those residents who have special needs due to dementia or a medical condition, illness or injury. Every residential health facility shall post, for each shift, the names and titles of the nursing services direct caregivers assigned to each floor, unit or wing and the nursing supervisor on duty. This information shall be conspicuously displayed in common areas of the facility, in no fewer number than the number of nursing stations. Every residential health facility employee shall wear a nametag prominently displaying his or her full name and title. Personnel hired through temporary agencies shall be required to wear photo identification listing their names and titles.** **This requirement is not met as evidenced by:** Based on observations made throughout the survey and interview, it was determined that the facility failed to post nursing services staffing on each unit of the Health Center. Findings include: 1. The staff posting was located on the Rehoboth Unit. There was no comparable staff posting available on the Lewes unit. An interview on 10/24/12 with E2, D.O.N., indicated that the posting was on the Rehoboth Unit and verified that it was not on the Lewes Unit.	4. Findings will be reported monthly at QA meetings for the next 3 months, then quarterly x two. 11/19/12 Cross refer to the CMS 2567-L Survey report dated 10/24/12, F157, F242, F247, F279, F280, F309, F325, F329, F334, F428, F441.

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